EFFECTIVE: 04/01/2015

UPDATE: 10/15//2015

## Background

Effective for dates of service on and after April 1st 2015, AHCCCS pays the all-inclusive per visit PPS rate on a per claim basis for providers registered as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), replacing the previous method of reimbursing claims reported under individual FQHC/RHC employed practitioners by the capped fee-for-service fee schedule and annually reconciling to the PPS rate. The method for calculating the all-inclusive per visit PPS rates will not change.

AHCCCS will continue to perform annual reimbursement reconciliations. Additionally, AHCCCS anticipates that quarterly supplemental payments will continue, though in amounts appropriate to the expectation that the MCOs will, in most cases, be paying the PPS rate. MCOs may continue to establish sub-capitated reimbursement arrangements.

A provider designated by CMS as an FQHC or FQHC Look-Alike (FQHC-LA) will be registered by AHCCCS with an AHCCCS provider type of C2 (FQHC). A provider designated by CMS as an RHC will be registered by AHCCCS with an AHCCCS provider type of 29 (RHC). To be eligible for the PPS per visit rate claims must be reported under the FQHC or RHC.

## Definitions

"FQHC/RHC visit" means: A face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

Services "incident to" a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician's or practitioner's professional service (examples: medical supplies; venipuncture; assistance by auxiliary personnel such as a

nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (examples: x-ray; medication; laboratory test).

## Billing Guidelines

*Please note: FQHC pharmacy billing will remain under the pharmacy provider type and is not be impacted by this change.*

For dates of service on and after April 1st 2015, in order to qualify for PPS reimbursement all FQHC, FQHC-LA, and RHC providers must utilize the appropriate NPI for the FQHC or RHC as the rendering provider for the claim (Note: PPS reimbursement will only apply to the FQHC or RHC provider). For electronic billing applicable reporting standards apply (Billing Provider Loop – Required, sent for every transaction and Rendering Provider Loop – Situational, sent if the rendering provider is different than the billing provider).

PPS visits must be billed on a Form 1500, 837Professional format, ADA Form or 837Dental format as appropriate to the type of PPS eligible visit and utilize appropriate place of service coding (11-Office, 22-Outpatient, 49-Independent Clinic, 50-FQHC, 71-Public Health or 72-RHC).

For purposes of reimbursing PPS eligible visits, AHCCCS has adopted the T1015 (Clinic visit/encounter, all-inclusive) procedure code for FQHC physical, behavioral health and dental visits. This procedure code should be reported on all claims to designate an FQHC/RHC visit and receive PPS reimbursement.

Billed charges associated with the T1015 procedure code should reflect the appropriate PPS rate for the FQHC/RHC to ensure full PPS reimbursement. If something less than the PPS rate is used to report billed charges for the T1015 visit code, the AHCCCS "lesser of" reimbursement policy will prevail and cause the claim to be paid a rate less than the PPS rate.

A visit is identified by, and reimbursement for the visit is associated with, the T1015 code; all other covered services reported on the claim are bundled into the visit and valued at $0.00 for reimbursement purposes.

In addition to the T1015 PPS visit code, claims must continue to include all appropriate covered procedure codes (including appropriate E&M codes) describing the services rendered as part of the visit. If no covered procedure codes are reported in conjunction with the T1015 visit code or if there is no T1015 visit code reported, no PPS reimbursement will apply.

For dates of service on and after April 1st 2015, traditionally global services such as deliveries and or surgery pre and post op days will no longer be treated as packages; however, they will be eligible for PPS visit reimbursement and, therefore, will require split billing.
Services which do not accompany a visit but are "incident to" that visit based upon the definition (lab, radiology, immunizations or other testing) are not separately reimbursed.

Multiple visits on the same day within the same discipline which are distinct based upon the FQHC/RHC visit definition above must be identified by billing -the T1015 visit code for the same-day subsequent visit with a modifier 25 to indicate a distinct and separate visit.

In order to retain information related to the actual professional practitioner (provider) participating in/performing services associated with PPS visits, that professional practitioner (provider) participating in/performing services must also be reported on all claims as outlined below.

### Instructions for Billing Participating/Performing Professional Practitioner:

CMS Form 1500 (Paper/Web Claim): ITEM NUMBER 19 - TITLE: Additional Claim Information

Format Examples:

One Participating/Performing Provider - XXNPIProviderName (last, first 20 characters)
Example –
XX1987654321Smitherhouse, Michelle

Two Participating/Performing Providers –
XXNPIProviderName (last, first 20 characters) 3 blanks XXNPIProviderName (last, first 20 characters)
Example –
XX1987654321Smitherhouse, Michelle XX2123456789Fredricksburg, Cynthia

ADA Form (Paper/Web Claim): Field 35. Remarks

Format Examples:

One Participating/Performing Provider - XXNPIProviderName (last, first 20 characters)
Example –
XX1987654321Smitherhouse, Michelle

Two Participating/Performing Providers –
XXNPIProviderName (last, first 20 characters) 3 blanks XXNPIProviderName (last, first 20 characters)
Example –
XX1987654321Smitherhouse, Michelle XX2123456789Fredricksburg, Cynthia

837 Professional (Electronic Claim): 2300 NTE

Format Examples:

One Participating/Performing Provider – XXNPI ProviderName (last, first 20 characters)
Example – see below

Two Participating/Performing Providers –XXNPIProviderName (last, first 20 characters)3 blanksXXNPIProviderName (last, first 20 characters)
Example – see below

| Loop | Element | Description 837-P 5010 A1 ENC | ID | Min. Max. | Use | Note | AHCCCS Usage/Expected Value (Codes/Notes/Comments) |
|---|---|---|---|---|---|---|---|
| **2300** | **NTE** | **CLAIM NOTE** | | **1** | **S** | | |
| 2300 | NTE01 | Note Reference Code | ID | 3-3 | R | ADD=Additional Information<br>CER=Certification Narrative<br>DCP=Goals, Rehabilitation Potential, or Discharge Plans<br>DGN=Diagnosis Description<br>TPO=Third Party Organization Notes | Expect 'ADD' – Additional Information |
| 2300 | NTE02 | Claim Note Text | AN | 1-80 | R | Expect Claim Note Text<br>Ex: Reporting 1 Provider:<br><br>Ex: Reporting 2 Providers: | <br>XX1987654321 SMITHERHOUSE, MICHELLE<br><br>XX1987654321 SMITHERHOUSE, MICHELLE XX2123456789FREDRICKBURG, CYNTHIA |

837 Dental (Electronic Claim): 2300 NTE

Format Examples:

One Participating/Performing Provider –XXNPIProviderName (last, first 20 characters)
Example – see below

Two Participating/Performing Providers – XXNPIProviderName (last, first 20 characters)3 blanksXXNPIProviderName (last, first 20 characters)
Example – see below

| Loop | Element | Description 837-D 5010 A2 ENC | ID | Min. Max. | Use | Note | AHCCCS Usage/Expected Value (Codes/Notes/Comments) |
|---|---|---|---|---|---|---|---|
| **2300** | **NTE** | **CLAIM NOTE** | | **1** | **S** | | |
| 2300 | NTE01 | Note Reference Code | ID | 3-3 | R | ADD=Additional Information<br>CER=Certification Narrative<br>DCP=Goals, Rehabilitation Potential, or Discharge Plans<br>DGN=Diagnosis Description<br>TPO=Third Party Organization Notes | Expect 'ADD' – Additional Information |
| 2300 | NTE02 | Claim Note Text | AN | 1-80 | R | Expect Claim Note Text | Ex. Reporting 1<br>XX1987654321 SMITHERHOUSE, MICHELLE<br><br>Ex. Reporting 2<br>XX1987654321 SMITHERHOUSE, MICHELLE XX2123456789FREDRICKBURG, CYNTHIA |

- Do not enter a space, hyphen, slash or other separator between the qualifier code and the NPI number or between the NPI and the Provider Name.
- When reporting a second item of data, enter three blank spaces and then the next qualifier and number/code/Provider Name.
- XX is the actual Qualifier Code designated by the standards body to indicate an NPI.
- At this time reporting of Participating Providers beyond 2 occurrences is not supported as defined in the standards for these transactions. If Participating Providers beyond 2 occurrences exist for a single claim, only the first two occurrences should be reported.

## Billing Examples

Examples 1500:

Example Claim #1 – (based on actual services to a recipient on the same day) (may be billed on multiple claim forms or a single claim form)

| | | |
|---|---|---|
| PROC: 99202 | PROC: T1015 | PROC: 84005 |
| MOD: | MOD: | MOD: 26 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| BILLED CHRGE: 114.00 | BILLED CHRGE: 160.00 | BILLED CHARGE: 24.00 |
| PAY: 0.00 | PAY: PPS Rate *(or Billed Charge if less)* | PAY: 0.00 |

Example Claims #2 and #3 – (based on actual services for the same recipient over a period of time) (each claim example may be billed on multiple claim forms or a single claim form)

BEGIN/END DATES OF SERVICE – 5/1/2015

| | | |
|---|---|---|
| PROC: T1015 | PROC: 99213 | PROC: 84005 |
| MOD: | MOD: | MOD: 26 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| BILLED CHRGE: 160.00 | BILLED CHRGE: 90.00 | BILLED CHARGE: 90.00 |
| PAY: PPS Rate ***(or Billed Charge if less)*** | PAY: 0.00 | PAY: 0.00 |

BEGIN/END DATES OF SERVICE – 6/10/2015

| | | |
|---|---|---|
| PROC: T1015 | PROC: 99213 | PROC: 74000 |
| MOD: | MOD: | MOD: 26 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| BILLED CHRGE: 160.00 | BILLED CHRGE: 90.00 | BILLED CHARGE: 90.00 |
| PAY: PPS Rate *(or Billed Charge if less)* | PAY: 0.00 | PAY: 0.00 |

Example Claim #4 – (No T1015 billed)

| | |
|---|---|
| PROC: 99213 | PROC: 74000 |
| MOD: | MOD: |
| UNITS: 1.000 | UNITS: 1.000 |
| BILLED CHRGE: 114.00 | BILLED CHARGE: 124.00 |
| PAY: 0.00 | PAY: 0.00 |

Examples ADA:

Example Claim #1 – (based on actual services to a recipient on the same day) (may be billed on multiple claim forms or a single claim form)

| | | |
|---|---|---|
| PROC: D7111 | PROC: T1015 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER: J | TOOTH NUMBER: | TOOTH NUMBER: J |
| SURFACE: | SURFACE: | SURFACE: |
| ORAL CAVITY: | ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE: 114.00 | BILLED CHRGE: 160.00 | BILLED CHARGE: 24.00 |
| PAY: 0.00 | PAY: PPS Rate *(or Billed Charge if less)* | PAY: 0.00 |

Example Claims #2 and #3 – (based on actual services for the same recipient over a period of time) (each claim example may be billed on multiple claim forms or a single claim form)

BEGIN/END DATES OF SERVICE – 5/1/2015

| | | |
|---|---|---|
| PROC: T1015 | PROC: D2392 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER: | TOOTH NUMBER: 28 | TOOTH NUMBER: 29 |
| SURFACE: | SURFACE: O D | SURFACE: O D |
| ORAL CAVITY: | ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE: 160.00 | BILLED CHRGE: 90.00 | BILLED CHARGE: 90.00 |
| PAY: PPS Rate *(or Billed Charge if less)* | PAY: 0.00 | PAY: 0.00 |

BEGIN/END DATES OF SERVICE – 6/10/2015

| | | |
|---|---|---|
| PROC: T1015 | PROC: D2392 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER: | TOOTH NUMBER: 28 | TOOTH NUMBER: 29 |
| SURFACE: | SURFACE: O D | SURFACE: O D |
| ORAL CAVITY: | ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE: 160.00 | BILLED CHRGE: 90.00 | BILLED CHARGE: 90.00 |
| PAY: PPS Rate *(or Billed Charge if less)* | PAY: 0.00 | PAY: 0.00 |

Example Claim #4 – (No T1015 billed)

BEGIN/END DATES OF SERVICE – 6/10/2015

| | |
|---|---|
| PROC: D2392 | PROC: D0220 |
| UNITS: 1.000 | UNITS: 1.000 |
| TOOTH NUMBER: 28 | TOOTH NUMBER: 29 |
| SURFACE: O D | SURFACE: O D |
| ORAL CAVITY: | ORAL CAVITY: |
| BILLED CHRGE: 90.00 | BILLED CHARGE: 90.00 |
| PAY: 0.00 | PAY: 0.00 |

For additional examples related to areas including EPSDT visits; multiple visits on the same date of service; global billing situations; Medicare and OTI primary, please refer to the FQHC/RHC page on the AHCCCS website at the following link.
http://www.azahcccs.gov/commercial/FQHC-RHC.aspx

## FFS Billing Instructions with a Primary Payer

When Medicare is primary payer
Crossover claims are received electronically from the Medicare plan with Medicare's specified coding that will not match to AHCCCS coding requirements.

The FQHC/RHC provider must Void the crossover claim and resubmit on a 1500 claim form with the AHCCCS specified coding and include a copy of the EOMB.

On the 1500 claim form Medicare's deductible/coinsurance/copay total amounts *must* be reported on the T1015 claim line for reimbursement in the correct Medicare fields. The appropriate EM codes must be billed on successive lines with 0.00 billed amount and leaving the Medicare fields blank (do *not* enter 0's).

If the Medicare claim did not crossover, the FQHC/RHC must submit the claim with the EOMB, even though the codes billed will not match the EOMB. The Medicare deductible/coinsurance/copay total amounts *must* be reported on the T1015 service line, in the correct Medicare fields, for reimbursement. The appropriate EM codes must be billed on successive lines with 0.00 billed amount, leaving the Medicare deductible/coinsurance/copay fields blank (do *not* enter 0's).

When other coverage paid as primary
The FQHC/RHC must submit the claim with the total amount paid by the other primary payer entered on the T1015 service line only (in the correct OT fields).

The appropriate EM codes must be billed on successive lines with 0.00 billed amount, leaving the other payer fields blank (do *not* enter 0's). A copy of the primary payer's EOB must be included with the claim. Since AHCCCS specifies the T1015 coding, the billing and the EOB coding will not match.

## Revision/Update History

| Date | Description of changes | Page(s) |
|---|---|---|
| 10/15/2015 | Correction: Paper/Web Claims<br>For clarification, added new section "FFS Billing Instructions with a Primary Payer" | 3<br>8,9 |
| 04/01/2015 Effective | FQHC/RHC Addendum | all |